MoDOT/MSHP Medical Plan Summary of Benefits for Non-Medicare Participants
Effective January 1, 2010

Listed below is a partial outline of health services covered under the MoDOT/MSHP Summary Plan Document (SPD). This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP SPD for applicable limits and exclusions to coverage for these health services. If differences exist between this summary of benefits and the SPD, the SPD governs.

Benefit	Coventry PPO PLAN Available Statewide	
	In Network Provider	**Out of Network Provider ***
	Member's Responsibility (per calendar year)	
Deductible Individual Family	 $ 350 $ 1,050 maximum	 $ 350 $ 1,050 maximum
Coinsurance	10% (up to out-of-pocket maximum)	20% (up to out-of-pocket maximum)
Out-of-Pocket Maximum Individual Family	per calendar year (does not include deductible and copayment) $825 $2,475	per calendar year (does not include deductible and copayment) $1,650 $4,950
Lifetime Maximum	Unlimited	Unlimited
Office Visit	$20 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of allowed amount after deductible
Immunizations Covered for Dependent Children According to "Recommended Childhood, Adolescent and Adult Immunization Schedules" (See Appendix B in Plan Document)	$0 copayment or 0% coinsurance of eligible expenses.	20% coinsurance of allowed amount after deductible
Preventive Care Subscriber and Enrolled Spouse (Non-Medicare)	$350 (covered at 100% for preventive services only) Member responsible for amount in excess of $350 per calendar year.	$350 (covered at 100% for preventive services only) Member responsible for amount in excess of $350 per calendar year.
Preventive Care Dependent Children from Birth through 5 years of Age	$0 copayment or 0% coinsurance for all well-child care visits	$0 copayment or 0% coinsurance for all well-child care visits
Preventive Care Dependent Children 6 years of Age and Older (Non-Medicare)	$200 (covered at 100% for preventive services only) Member responsible for amount in excess of $200 per calendar year.	$200 (covered at 100% for preventive services only) Member responsible for amount in excess of $200 per calendar year.
Inpatient Hospital Care	10% coinsurance after deductible. Pre-admission certification required	20% coinsurance of allowed amount after deductible. Pre-admission certification required
Urgent Care	$20 copayment for office visit only. Other services applied to deductible and coinsurance	20% coinsurance of allowed amount after deductible
Surgery	10% coinsurance after deductible. Pre-admission certification required, if inpatient.	20% coinsurance of allowed amount after deductible. Pre-admission certification required, if inpatient.
Allergy Injections	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.
Emergency Room Services	$75 copayment and 10% coinsurance after deductible. Copayment waived if admitted or accidental injury.	$75 copayment and 20% coinsurance of allowed amount after deductible. Copayment waived if admitted or accidental injury.
Maternity	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.
Chiropractic Services	10% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	20% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.
Mental Health (MH)/Chemical Dependency (CD) - Inpatient	10% coinsurance after deductible. Pre-admission certification required.	20% coinsurance of allowed amount after deductible. Pre-admission certification required.
Mental Health (MH)/Chemical Dependency (CD) - Outpatient	Outpatient office visit: $20 copayment; Outpatient hospital: 10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.
Organ Transplant Coverage		
Organ Transplants	100% coverage for transplant and 18 months following the transplant.	20% of network cost to the closest in-network facility plus the difference between the network and actual cost.
Pharmacy Benefit - Available Through Participating Pharmacies Only		
Deductible	$100 per participant per calendar year	
Coinsurance	30% of costs after deductible is met (minimum $5 copay)	
Starter Quantity	30 day starter quantity for new medication, including change in strength, or the medication has not been filled for the previous six months	
Generic Policy	**If a generic is available:** 30% coinsurance of brand drug's cost plus the difference between the brand and generic after calendar year deductible at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 30% coinsurance after calendar year deductible at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by WellPoint NextRX:** 30% coinsurance after calendar year deductible at retail and mail order pharmacy with $5 minimum copayment.	
Quantity	Purchase 90 days at participating retail pharmacies or the mail order pharmacy for maintenance medications.	
Prior Authorization	Some drugs may require a prior authorization. Contact the pharmacy benefits number on your prescription drug card.	

*** Out of Network Provider service insurance payments are subject to Usual and Customary Rates (UCR) only. The Member will be responsible 100% for amounts above UCR.**